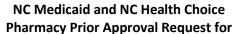


NC Medicaid and NC Health Choice Pharmacy Prior Approval Request for Sovaldi: Initial PA Form

Beneficiary Information 2. First Name: _____ 1. Beneficiary Last Name: _____ 4. Beneficiary Date of Birth: 5. Beneficiary Gender: 3. Beneficiary ID #: _____ Prescriber Information 6. Prescribing Provider NPI #: 7. Requester Contact Information - Name: ______ Phone #: _____ Ext. __ Drug Information _ 9. Strength: ______ 10. Quantity Per 30 Days:__ 8. Drug Name: ___ 11. Length of Therapy (in days):

8 Weeks (Do not change. Only 8 weeks can be approved with this form. You must use continuation form to request last 4 weeks) Clinical Information Total Length of Therapy (Check ONE): ☐ 12 weeks = Genotype 1, 2, or 4 for treatment-naïve and treatment-experienced adult beneficiaries without cirrhosis or with compensated cirrhosis (child-pugh A); or genotype 2 for treatment-naïve and treatment-experienced pediatric patients, 3 years of age or older, without cirrhosis or with compensated cirrhosis (child-pugh A). Genotype 1 and previously treated with a regimen containing an NS3/4A PI₂ without prior treatment with an NS5A inhibitor ☐ **24 weeks** = Genotype 1 adult beneficiaries that are PEG-interferon ineligible; genotype 3 for treatment-naïve and treatment experienced adults without cirrhosis or with compensated cirrhosis (child-pugh A); Or genotype 3 for treatment-naïve and treatment-experienced pediatric patients, 3 years of age or older, without cirrhosis or with compensated cirrhosis (child-☐ 48 weeks = Genotype 1,2,3, or 4 for adult beneficiaries with a diagnosis of Hepatocellular Carcinoma awaiting liver transplantation (up to 48 weeks or until liver transplantation, whichever comes first) 1. Does the beneficiary have a diagnosis of chronic hepatitis C infections with one of the following confirmed diagnosis': ☐ Genotype 1 or 4 without cirrhosis or with compensated cirrhosis and beneficiary is 18 years of age or older ☐ Genotype 2 or 3 without cirrhosis or with compensated cirrhosis and beneficiary is 3 years of age or older ☐ Beneficiary has CHC infection with hepatocellular carcinoma awaiting liver transplant 2. Are medical records documenting the diagnosis of chronic hepatitis C with genotype and subtype being submitted with this request? Yes No **Lab test results MUST be attached to the PA to be approved.** 3. Which of the following are included with the submitted medical records to document the staging of liver disease? ☐ Metavir scores ☐ FibroSure score ☐ IASL scores ☐ Batts-Ludwig scores ☐ Fibroscan score ☐ Ishak scores ☐ APRI scores ☐ Radiological imaging consistent with cirrhosis ☐ Physical findings or clinical evidence consistent with cirrhosis as attested by the prescribing physician 4. Does the beneficiary have a documented quantitative HCV RNA at baseline that was tested within the past 6 months (medical documentation required)? ☐ Yes ☐ No HCN RNA (IU/ml): and/or log10 value: 5. A commitment to abstinence from alcohol and IV drug use is required. For beneficiaries with a recent history of alcohol abuse or IV drug use (within the past year), enrollment in a treatment program and/or counseling, and/or an active support group is also required. Beneficiaries must agree to toxicology and/or alcohol screens as needed. Does the beneficiary have a history of alcohol abuse or IV drug use? ☐ Yes ☐ No 6. As the provider, are you reasonably certain that treatment will improve the beneficiary's overall health status? ☐ Yes ☐ No 7. Do you attest that the beneficiary has been evaluated for readiness for treatment and the beneficiary agrees to be compliant





with therapy, follow-up appointments and labs? \square Yes \square No
8. Is Sovaldi being prescribed in combination with ribavirin and pegylated interferon alfa for genotypes 1 and 4? Yes No
9. Is Sovaldi being prescribed in combination with ribavirin for beneficiaries with genotype 1 who are peginterferon-ineligible
(medical record documentation of previous peginterferon therapy or reason for ineligibility must be submitted for review)?
☐ Yes ☐ No
10. Is Sovaldi being prescribed in combination with ribavirin for genotypes 2 and 3 and/or in CHC beneficiaries with hepatocellular
carcinoma awaiting liver transplant? \square Yes \square No
11. Is Sovaldi being used as monotherapy? Yes No
12. Is Sovaldi being used with any other sofosvuvir containing regimen? \square Yes \square No
13. Does the beneficiary have any FDA labeled contraindications to sofosbuvir (Sovaldi)? \square Yes \square No
14. Is the Beneficiary pregnant? \square Yes \square No
15. Does the beneficiary have severe renal impairment (CrCl less than 30 mL/min), end stage renal disease, or require dialysis
(AASLD/IDSA 2014)? \square Yes \square No
16. Is the beneficiary a non-responder to sofosbuvir? \square Yes \square No
17. Has the beneficiary previously failed therapy with a treatment regimen that included sofosbuvir? \Box Yes \Box No
18. Does the beneficiary have hepatocellular carcinoma and is not awaiting a liver transplant? \Box Yes \Box No
Signature of Prescriber: Date:
(Prescriber Signature Mandatory)
I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any

falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSRA at (855) 710-1969 DHB Pharmacy 32

Pharmacy PA Call Center: (866) 246-8505 02/25/21